

365234

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83

34705

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GLENN		2a. DATE OF DEATH MONTH DAY YEAR 11 18 85		2b. HOUR HOUR MIN. 8 45 PM	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 9 18 01	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown		7b. CITIZEN OF WHAT COUNTRY? Unknown		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13 S/H		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinetmaker		12b. KIND OF BUSINESS OR INDUSTRY —		13a. STREET ADDRESS / ZIP CODE 21871	
13a. STATE MD		13b. COUNTY Somerset		13c. CITY OR TOWN Weymouth	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 214-32-1813A		17. INFORMANT Logan Widdowson		ADDRESS Pt Anne, Md 21853	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ASCVD		19a. DATE OF OPERATION —	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/05 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 11/18 85	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — —	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11/18 19 85 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE George H. Beck MD		22c. DATE SIGNED 11/18/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE H. BECK MD		22e. ADDRESS East St. Hosp. Ctr. Cambridge, MD 21613		22f. DATE SIGNED 11/18/85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov 19, 1985		23c. NAME OF CEMETERY OR CREMATORY Salisbury	
23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico MD		24. FUNERAL DIRECTOR NAME ADDRESS Hillman Funeral Home Princess Anne, Md		25a. DATE REC'D. BY REGISTRAR NOV 26 1985	
25b. REGISTRAR'S SIGNATURE John Widdowson		25c. REGISTRAR'S SIGNATURE John Widdowson		25d. REGISTRAR'S SIGNATURE John Widdowson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be placed in the container for the body and page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or release.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP _____

014025

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Howard U. Bloom, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 12/30/85			2b. HOUR 7^{PM}				
3. SEX M		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 10 15 17		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD-		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.				
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DGH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md			13b. COUNTY DORCH		13c. CITY OR TOWN CAMB		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 520 Glenburn Ave	
14. FATHER'S NAME FIRST MIDDLE LAST MILLARD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA W HEATLEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-07-8591		17. INFORMANT Evelyn Bloom		ADDRESS 943-4658			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) DECUBITUS ULCER DUE TO, OR AS A CONSEQUENCE OF (c) CVA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: OBS, RECURRENT UTI										
19a. DATE OF OPERATION 11/25			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/25 , 19 85 , to 12/30 , 19 80 , that (I) (we) lost saw the deceased alive on 12/30 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Hubert L. Ferry			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/30/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT L. FERRY			22e. ADDRESS 503 BYRN ST.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 1/3/86		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Mem. Gardens, Salisbury, Wic., Md.			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME					ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR JAN 9 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP _____

TO THE SECRETARY OF THE INTERIOR
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing land management activities, possibly related to a specific area or project. Key words that are faintly visible include "Bureau of Land Management", "Secretary of the Interior", and "Director".]



TO
FROM



010013

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Lady L. Brooks			2a. DATE OF DEATH MONTH DAY YEAR 12/30/85		2b. HOUR 6:10 AM	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug. 16, 1914		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 71		
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.			13b. CITY OR TOWN Dor.		13c. STREET ADDRESS 126 Brohawn Ave. 21613	
14. FATHER'S NAME FIRST MIDDLE LAST Willard Sprouse			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Davis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-36-6273		17. INFORMANT ADDRESS Ernest W. Brooks Item # 13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **SEPTICEMIA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b) **URINARY TRACT INFECTION**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**2 DAYS****2 wks.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

CEREBROVASCULAR ATTACK WITH PARESIS

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-26 , 19 85 , to 12-30 , 19 85 , that (I) (we) lost saw the deceased alive on 12-29-85 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.							
22b. SIGNATURE David Harper MD				DEGREE MD		22c. DATE SIGNED 12-30-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID HARPER MD				22e. ADDRESS 402 BYRAN ST CAMBRIDGE MD 21613			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 1/2/86		23c. NAME OF CEMETERY OR CREMATORY E. NEW MARKET CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE E. NEW MARKET DOR. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS THOMAS FUNERAL HOME CAMBRIDGE MD.				25a. DATE REC'D. BY REGISTRAR JAN 9 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Pondell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

353172

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Daniel DeLarge, Jr.		2a. DATE OF DEATH MONTH DAY YEAR December 4, 1985		2b. HOUR M P 2 M	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR August 4, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philadelphia, Pa.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10. CITY OR TOWN OF DEATH Vienna, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RFD 1, Box 239		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N.J. State Highway Dept.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE New Jersey		13b. CITY OR TOWN Lawnside		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel DeLarge, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lela Gates			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 161-24-3640		17. INFORMANT ADDRESS 21869 Evelyn Farrare, RFD 1, Box 239, Vienna, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-28</u> 19 <u>85</u> , to <u>12-4</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>11-30</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Michael J. Fadden</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael J. Fadden, M.D.		22e. ADDRESS 302 Collins Avenue, Hurlock, Maryland 21643			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 7, 1985		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Rhodesdale, Dorchester, Md.		23e. DATE REC'D. BY REGISTRAR DEC 16 1985			
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home,		ADDRESS Federalburg 216 N. Main St.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16-80A 1/73

(VR A 15 (4))

2023

353079

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Juliana Mary Duffy				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12/16 1985				2b. HOUR 2:23 AM	
3. SEX F	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 1-9-15	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 12/16 1985		2d. HOUR 2:23 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GRATON, VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.			
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOSPITAL WORKER		12b. KIND OF BUSINESS OR INDUSTRY MEDICAL	
13a. STATE MD.			13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD AUGUSTINE DUFFY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA MARY HOSE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 218-14-5619			17. INFORMANT IRENE M. DUFFY 6 Bay Heights Ave, Cambridge, MD 21613						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a). NONE KNOWN									
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? N/A				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) NO INJURY				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Donald R. McWilliams			TITLE (SPECIFY) DEPUTY			DATE SIGNED 12/16/85			
EXAMINER'S NAME (TYPE OR PRINT) DONALD R. McWILLIAMS, M.D.			ADDRESS 308 GAY ST CAMBRIDGE, MD 21613						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/17/1985		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Walter Brooks Bradley Inc. Balto., Md. 21222				25a. DATE REC'D. BY REGISTRAR DEC 17 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGE 5 SHOULD BE FILED WITHIN 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

For the right of way
of the road

3

1000

006213

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 3 4 / 1 0			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST Thelma		MIDDLE Aaron		LAST Fitzhugh		2a. DATE OF DEATH		MONTH 12	DAY 24	YEAR 85	2b. HOUR 5.47 PM
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Dec 20, YEAR 1924		6. AGE (IN YEARS (LAST BIRTHDAY)) 61 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD.							
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 727 Roselyn Avenue 21613					
14. FATHER'S NAME FIRST Cecil MIDDLE Aaron LAST				15. MOTHER'S MAIDEN NAME FIRST Ellen MIDDLE Price LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-20-3912		17. INFORMANT ADDRESS Levin M. Fitzhugh Item # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myo. infarction</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary H. Disease</u>													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pulmonary Edema, CHF, D. Mellitus, Hypertension</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>E. Tanman</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-24-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Tanman				22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/27/85		23c. NAME OF CEMETERY OR CREMATORY Md. Vets Cemetery				23d. LOCATION CITY OR TOWN Hurlock, Dor. COUNTY Md. STATE			
24. FUNERAL DIRECTOR NAME Thomas Funeral Home 700 Locust St. Md.				25a. DATE REC'D. BY REGISTRAR DEC 31 1985				25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>					

MEDICAL CERTIFICATION

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353155

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the appropriate pages. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR				7 5 3 4 / 1 1	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ruby ELVEDA Goodman</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12-6-85</i>		2b. HOUR <i>7:19 P.M.</i>
3. SEX <i>female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>April 21, 1924</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Arkansas</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i> MD.	
10. CITY OR TOWN OF DEATH <i>Cambridge</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester General Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retailer, self employed</i>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13e. STREET ADDRESS / ZIP CODE		
13a. STATE <i>Md.</i>	13b. COUNTY <i>Dor.</i>	13c. CITY OR TOWN <i>Cambridge</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<i>321 Choptank Ave. 21613</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Daniel Barnett</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret unk.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>334-26-0311</i>	17. INFORMANT ADDRESS <i>Lowell R. Goodman Item # 13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxial Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic CA Lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>Approx 10-14-85</i> , to <i>12-6-85</i> , that (1) (we) lost saw the deceased alive on <i>12-6-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Mr. J. R. Bellon</i>		DEGREE		22c. DATE SIGNED <i>12-6-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>12/12/85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lawrence Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Walnut Ridge, Lawrence, Ark</i>
24. FUNERAL DIRECTOR NAME <i>THOMAS FUNERAL HOME CAMBRIDGE MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 13 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Seiden</i>	

BP _____

1932-33

352148

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 3 4 / 1 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE GORDON LAST Howard			2a. DATE OF DEATH MONTH 12 DAY 1 YEAR 85		2b. HOUR 11 10 AM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH 10 DAY 16 YEAR 1922	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.		
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) secretary	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST Milton MIDDLE LAST Flowers			15. MOTHER'S MAIDEN NAME FIRST Nellie MIDDLE LAST Tyler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-14-2814	17. INFORMANT ADDRESS James L. Howard Item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma left breast</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>With metastases to liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>9 years</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 26</u> 19 <u>85</u> , to <u>Dec 1</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Dec 1</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Lewis M. Burdette</u>		DEGREE MD		22c. DATE SIGNED <u>Dec 1 '85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lewis M. Burdette</u>		22e. ADDRESS <u>4 Harvard St Cambridge Md 21613</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 12/4/85	23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Pk. Cambridge Dor. Md.	23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR THOMAS FUNERAL HOME CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR DEC 10 1985			
		25b. REGISTRAR'S SIGNATURE <u>John T. Burdette</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

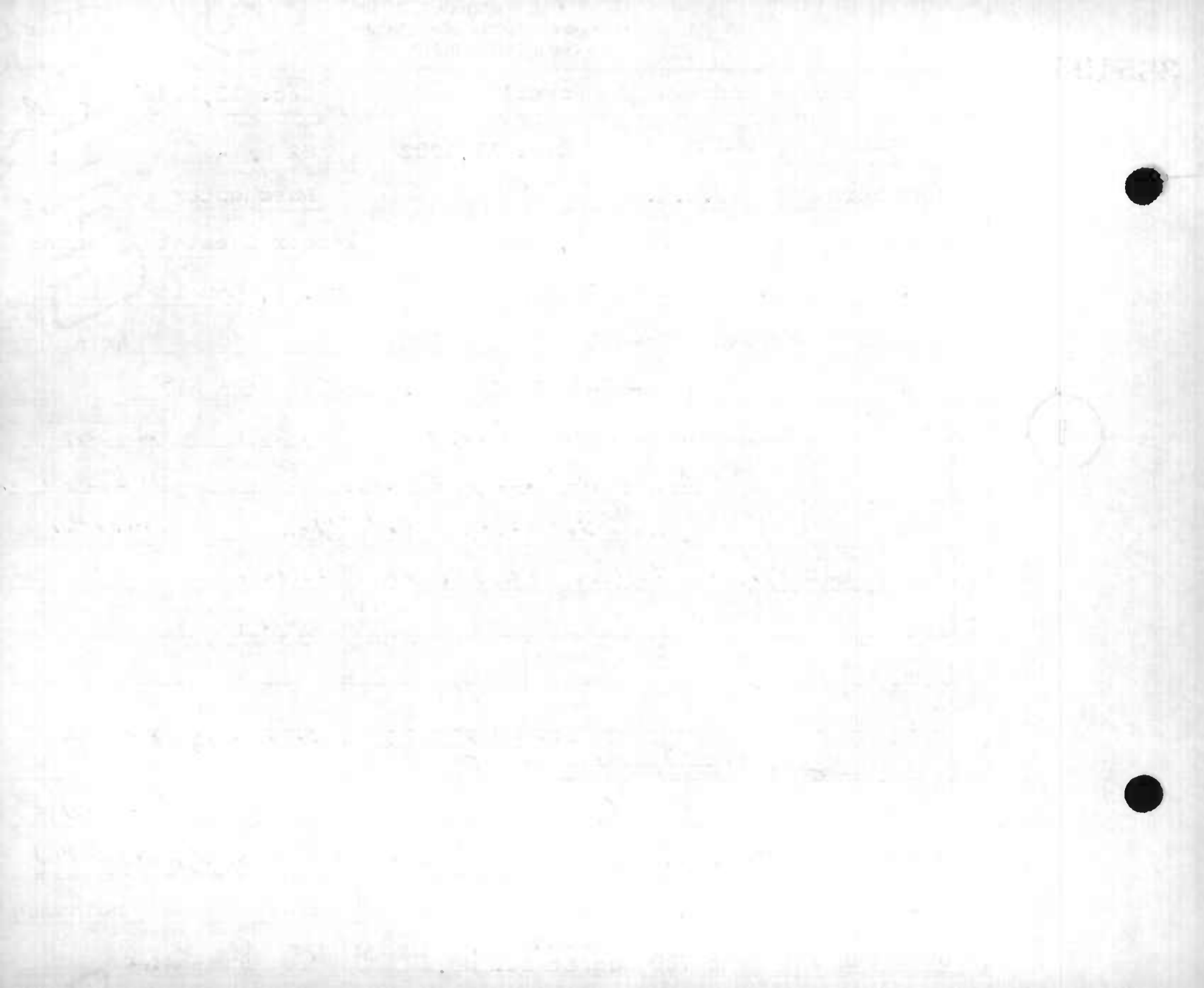
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IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Thomas Andrews Howell			2a. DATE OF DEATH MONTH DAY YEAR Dec. 13, 1985			2b. HOUR 1255 PM			
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR Dec. 17, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) rural route 1, Box 14				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer & estate manager		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS rt. 1, Box 14 21613	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Andrews Howell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Akin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 062-03-0481		17. INFORMANT ADDRESS Alice W. Howell Item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF (c) chronic debilitation, bedridden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 11 hours months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) COPD, CHF, hepatic failure, chronic renal failure									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 11 Nov 1983 to December 13 1985 , that (1) (we) last saw the deceased alive on Dec 13 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.									
22b. SIGNATURE Edmund J. MacLaughlin MD						DEGREE MD		22c. DATE SIGNED 12/13/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edmund J. MacLaughlin						22e. ADDRESS 10 Aurora St. Cambridge Md 21617			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/14/85		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Delaware		
24. FUNERAL DIRECTOR NAME ADDRESS Thomas Funeral Home 700 Locust St. Md. Cambridge						25a. DATE REC'D. BY REGISTRAR DEC 20 1985		25b. REGISTRAR'S SIGNATURE Alice W. Howell	

BP



014026

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 3 4 7 1 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN DORSEY Johnson			2a. DATE OF DEATH MONTH 12 DAY 29 YEAR 85			2b. HOUR 7:00p M.						
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH April DAY 7 YEAR 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.						
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) banker		12b. KIND OF BUSINESS OR INDUSTRY retired		
13a. STATE Md.			13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Indianbone Rd. 21613			
14. FATHER'S NAME FIRST James MIDDLE Colona LAST Johnson				15. MOTHER'S MAIDEN NAME FIRST Nettie MIDDLE LAST Condon								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-07-7954		17. INFORMANT Amanda I. Johnson			ADDRESS Rt 2 Box 367 Camb. Md. 21613				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) atheriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30'		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Malignant lung tumor												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE John A. Soerwald			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/29/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 1/2/86		23c. NAME OF CEMETERY OR CREMATORY Trinity Churchyard			23d. LOCATION CITY OR TOWN Church Creek COUNTY Dor. STATE Md.				
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME ADDRESS CAMBRIDGE MD.						25a. DATE RECEIVED BY REGISTRAR JAN 9 1986		25b. REGISTRAR'S SIGNATURE John Davidson				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Marjorie Evelyn Kapisak</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 28 85</i>			2b. HOUR <i>9 A M</i>			
3. SEX <i>female</i>		4. RACE <i>caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6 4 1894</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>91</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i> MD.			
10. CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cambridge House Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Tilghman</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Edward Vard Haddaway</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret Frances Cummings</i>			16. ADDRESS <i>P.O. Box 1209</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>218-16-5856</i>		17. INFORMANT <i>Ernest Thompson, P.R. Easton, Md. 21601</i>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASCVD & A. Fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Organic Brain Syndrome, Basal Cell Carcinoma, decubitus Ulcer</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>E. Tannan</i> M.D.				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. Tannan</i>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-31-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Tilghman Methodist</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Tilghman Talbot Md.</i>		23e. LOCATION CITY OR TOWN COUNTY STATE <i>Talbot Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Newnam Funeral Home, Easton, Md.</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

365217

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELba MAE Marshall			2a. DATE OF DEATH MONTH DAY YEAR 12 18 85			2b. HOUR 0130 ^M			
3. SEX F.		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 8 7 93		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE MD		13b. COUNTY DOR.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 136 Race St. 21613	
14. FATHER'S NAME FIRST MIDDLE LAST George Henry			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Merrick						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-28-2867		17. INFORMANT Franklin Marshall		ADDRESS Item # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction:</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10</u>									
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		21f. LOCATION STREET CITY OR TOWN COUNTY STATE - - - - -				
22a. I certify that (1) this hospital attended the deceased from <u>12-17-85</u> to <u>12-17-85</u> , that (1) (we) lost <u>12-17-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Wilice</u>			DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-18-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr Wilice			22e. ADDRESS 400 Maryland Ave						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 12/20/85		23c. NAME OF CEMETERY OR CREMATORY E. New Market Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE E. New Market Dor. Md.			
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR DEC 23 1985		25b. REGISTRAR'S SIGNATURE <u>John L. ...</u>		

MEDICAL CERTIFICATION

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

85

34

11

1. DECEASED NAME (TYPE OR PRINT) JAMES MASON			2a. DATE OF DEATH MONTH DAY YEAR 12 - 2 - 85			2b. HOUR 12 ⁴⁵ P.M.		
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 7 20 16			6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORC.			
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 809 Pine St / 21613			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Mason		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie 511/5						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-07-3937		17. INFORMANT Sarah Young				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Acute + chronic Renal failure

DUETO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) Malignant Hypertension

DUETO, OR AS A CONSEQUENCE OF

(c) Pan Acute M.I.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 11/26/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Urinary Retention		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John J. Devine				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John J. Devine				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/7/85		23c. NAME OF CEMETERY OR CREMATORY Lawrence Ceme	
23d. LOCATION CITY OR TOWN Lawrence		23e. COUNTY Va		23f. STATE Va	
24. FUNERAL DIRECTOR NAME Joe E. Bond Funeral Home				25a. DATE RECEIVED BY REGISTRAR DEC 5 1985	
25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 3 4 7 2 0

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>HAZEL H. MURPHY</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>12 15 85</u>		2b. HOUR <u>2:45</u> M
3 SEX <u>Female</u>	4 RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>October 5, 1892</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>93</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Dorchester Co.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester</u> MD.
10. CITY OR TOWN OF DEATH <u>Cambridge</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dorchester General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>	
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Dorchester</u>	13c. CITY OR TOWN <u>Federalsburg</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <u>Thomas W. Collison</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ola Mary Owens</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>820-00-0235</u>		17. INFORMANT ADDRESS <u>Federalsburg, Roy O. Murphy, Reliance Rd., Box 171, Md.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Circulatory Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastrointestinal bleed.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Ca Colon. Probable bowel infarction. Elevated WBC</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/15</u> 19 <u>85</u> , to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>H. A. Jaerwald MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>12/15/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>Dec. 18, 1985</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cemetery</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brookview, Dorchester, Maryland</u>
24. FUNERAL DIRECTOR NAME <u>FRAMPTON-HAWKINS</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 19 1985</u>	
ADDRESS <u>Box 43, FEDERALSBURG</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



354091

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HILDA MARIE ROBINSON			2a. DATE OF DEATH MONTH DAY YEAR 12-14-85		2b. HOUR 2:35 P.M.	
3. SEX F	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 20 19 66		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.		
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) seamstress		12b. KIND OF BUSINESS OR INDUSTRY clothing	
13a. STATE Maryland			13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ALFRED MC CLAIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERLIE ABBOTT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-28-4624		17. INFORMANT husband ADDRESS PHILLIP ROBINSON, same as 13c		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute D. Wall Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF A-S-I-D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. See 4m. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Logan		DEGREE		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) U-S. S. G. A. M. F. R. P.		22e. ADDRESS 105 Aurora St. Cambridge Md. 21613				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 12/17/85		23c. NAME OF CEMETERY OR CREMATORY Dor. Mem. Pk. Cem		
23d. LOCATION CITY OR TOWN COUNTY STATE Airey, Cambridge, Dor., Md.		23e. DATE REC'D. BY REGISTRAR DEC 18 1985				
24. FUNERAL DIRECTOR NAME Curran Funeral Home		25a. DATE REC'D. BY REGISTRAR DEC 18 1985				
25b. REGISTRAR'S SIGNATURE John Davidson-Randall						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked either (a) or (b), the medical examiner must be notified of this.

SECRET

358049

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column 1. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 3 4 7 2 2
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>Donna L. Souder</u>			2a. DATE OF DEATH MONTH <u>12</u> DAY <u>4</u> YEAR <u>85</u>			2b. HOUR <u>8:30</u> M					
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>8</u> DAY <u>12</u> YEAR <u>24</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>61</u> YRS.		7. IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		7. IF UNDER 24 HRS HOURS <u> </u> MIN. <u> </u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Missouri</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester County</u> MD.		
10. CITY OR TOWN OF DEATH <u>Cambridge</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dorchester General</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Contact Rep.</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>US Gov't.</u>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13b. COUNTY <u>Dorchester</u> 13c. CITY OR TOWN <u>E. New Market</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <u>Aberle Road/21631</u>					
14. FATHER'S NAME FIRST <u>Elmer</u> MIDDLE <u> </u> LAST <u>Lovan</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Katherine</u> MIDDLE <u> </u> LAST <u>Downey</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>			16b. SOCIAL SECURITY NO. <u>487-26-3538</u>			17. INFORMANT <u>Frederick J. Souder</u>			ADDRESS <u>at. 1, Box 133F8</u> <u>East New Market MD</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RESPIRATORY FAILUREDUE TO, OR AS A CONSEQUENCE OF METASTATIC(b) CARCINOMA OF LUNG

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) CARCINOMA OF LUNGAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHMINUTESMONTHSPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u> </u> P.M. <u> </u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/4</u> 19 <u>85</u> , to <u>12/4</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>12/4</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>David B. Steckle MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/4/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DAVID B. STECKLE MD</u>				22e. ADDRESS <u>200 MARYLAND AVE CAMBRIDGE, MD 21613</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>12-5-85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Delmarva Crematory</u>		23d. LOCATION CITY OR TOWN <u>Lewes</u> COUNTY <u>Sussex</u> STATE <u>Delaware</u>	
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24. FUNERAL DIRECTOR <u>Zeller Funeral Home, East New Market, MD</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 20 1985</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Rev. Nelson C. Stanley			2a. DATE OF DEATH MONTH DAY YEAR December 22, 1985			2b. HOUR M			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR June 23, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Madison, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH East New Market		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1, Box 14A				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister		12b. KIND OF BUSINESS OR INDUSTRY U. M. Church	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN E. New Market		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Box 14A 21631	
14. FATHER'S NAME FIRST MIDDLE LAST Hanson Stanley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Stanley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Market, Md. 21631 Margaret Stanley, Rt. 1, Box 14A, E. New					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF PANCREAS</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mo
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/7</u> 19 <u>82</u> , to <u>12/22</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>11/28</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Stephen P. Carney</u> 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Carney, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/26/85	
22e. ADDRESS Rt. 3, Box 106, Easton, Md. 21601							

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 28, 1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Nr. Salem, Dorchester, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Frampton-Hawkins Funeral Home, 216 N. Main St., Federalburg				DATE REC'D. BY REGISTRAR 12/31/85 REGISTRAR'S SIGNATURE <u>Julia Stanley</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ida E. Swilley			2a. DATE OF DEATH MONTH DAY YEAR 12-18-85			2b. HOUR 3:20 AM			
3. SEX F		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4 2 97		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 88	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DCH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William I. Kane			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Ruark			13e. STREET ADDRESS / ZIP CODE 711 Meaden Ave 21613			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-32-9420		17. INFORMANT Blond French			ADDRESS 574 Meaden Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) congestive heart failure fractured hip lactip APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ... Fracture Left hip									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12 10 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) at Fall					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Shower House		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Cambridge House Cambridge Md.					
22a. I certify that (I) (this hospital) attended the deceased from 12-10 , 19 85 , to 12-18 , 19 85 , that (I) (we) last saw the deceased alive on 12-18 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jay Hanson				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-18-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Hanson				22e. ADDRESS 304 Sandy Hill Rd					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 12/20/85		23c. NAME OF CEMETERY OR CREMATORY Dor. Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.			
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME				ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 12-23-85			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies of pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "at home," any injury, or other traumatic event, the medical examiner must be notified at once.

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FILE

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										3 4 7 2 6	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR			2c. DATE OF DEATH		
FIRST EARNEST			MIDDLE Thompson			LAST Thompson			MONTH DAY YEAR 12 11 1985		
3. SEX Male			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 12 25 97			6. AGE (IN YEARS) LAST BIRTHDAY 87 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER		
10. CITY OR TOWN OF DEATH CAMBRIDGE			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AIREY ROAD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER			12b. KIND OF BUSINESS OR INDUSTRY RETIRED		
13a. STATE MD			13b. COUNTY DOR			13c. CITY OR TOWN CAMBRIDGE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST WILLIAM			15. MOTHER'S MAIDEN NAME FIRST ROSIE			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS JOSEPHINE THOMPSON 402 CAMILLAS ST. CAMP, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8909 IMMEDIATE CAUSE (a) 3RD DEGREE BURNS 100% OF BODY DUE TO, OR AS A CONSEQUENCE OF (b) HOUSE FIRE DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM MONTH DAY YEAR P.M. 12-11 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) HOUSE FIRE					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET AIREY RD. CITY OR TOWN CAMBRIDGE COUNTY DORCHESTER STATE MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE James F. McCarter, M.D.			TITLE (SPECIFY) M.D.			MEDICAL EXAMINER			DATE SIGNED 12-11-85		
EXAMINER'S NAME (TYPE OR PRINT) JAMES F. MCCARTER			ADDRESS 400 AURORA ST. CAMP, MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREM-BURIAL			23b. DATE 12-16-85			23c. NAME OF CEMETERY OR CREMATORY VETERANS			23d. LOCATION ST. JULIAN COUNTY DORCHESTER STATE MD		
24. FUNERAL DIRECTOR NAME Frederick C. ...			25a. DATE REC'D. BY CLERK 12-13-85			25b. REGISTRAR'S SIGNATURE					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 5 3 4 1 2 1	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Joseph Whitelock Jr.			2a. DATE OF DEATH MONTH DAY YEAR 12 23 85		2b. HOUR 3:30 PM
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Mar 15, 1936	6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.		
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer-construction	
13a. STATE Md.		13b. COUNTY Dor.	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 406 Muir St. 21613
14. FATHER'S NAME FIRST MIDDLE LAST James Joseph Whitelock		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geraldine unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) U.S.M.C. 214-32-1479		17. INFORMANT ADDRESS Ruth Anne Whitelock Item # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUDDEN DEATH</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis Cardiovascular System</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>and. Cardiomypathy</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) (we) did not view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/23/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. E. A. M. W. R.		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 12/27/85	23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Beulah, Dor., Md.	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE DEC 31 1985 <i>[Signature]</i>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ARTHUR MONROE WILLEY, JR.			2a. DATE OF DEATH MONTH DAY YEAR 12 30 85			2b. HOUR 10:00 P.M.			
3. SEX male		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3 11 20		6. AGE (IN YEARS (LAST BIRTHDAY)) 65 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH Hurlock		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 2 Box 66 Hurlock				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Landscaper		12b. KIND OF BUSINESS OR INDUSTRY St. Highway Dept.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Dorchester		13c. CITY OR TOWN Hurlock		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Arthur M. Willey, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Kemp			13e. STREET ADDRESS / ZIP CODE Rt. 2 Box 66/21643			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1937-1959		17. INFORMANT Oleda M. Willey		ADDRESS see 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LARYNGEAL CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>6 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>g</u>									
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> 19 <u>80</u> to <u>12/30</u> 19 <u>85</u> , that (we) lost saw the deceased alive <u>5/3</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Michael A. Moskowitz</u> MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/7/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKOWICZ MD			22e. ADDRESS 503 134th ST. CAMBRIDGE MD. 21613						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-3-86		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cemetery Hurlock		23d. LOCATION CITY OR TOWN COUNTY STATE Dorchester Md.		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR JAN 13 1986		25b. REGISTRAR'S SIGNATURE <u>Michael A. Moskowitz</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

20% COTTON FIBER

CHARLEMAN

